Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	009669	A. BUILDING _____ B. WING _____	04/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA TANGLEWOOD TRACE	530 WEST TANGLEWOOD LANE MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey Dates: April 4, 5, and 6, 2011 Facility Number: 009669 Provider Number: 009669 AIM Number: N/A Survey Team: Toni Krakowski, RN TC Vicki Manuwal, RN Sandra Haws, RN Census Bed Type Residential: 91 Total: 91 Census Payor Type Other: 91 Total: 91 Sample: 7 Supplemental Sample: 2 Atria Tanglewood Trace was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey. Quality review 4/07/11 by Suzanne Williams, RN	R 000		